CHAPTER V

BILLING INSTRUCTIONS

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INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** – This section contains information about the timely filing of claims, claims inquiries, and supply procedures.
- **Billing Procedures** – Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

NORTHERN VIRGINIA LOCALITIES

For purposes of billing rates provided under the Elderly or Disabled with Consumer Direction Waiver, the following are considered the Northern Virginia localities:

Alexandria City
Arlington City
Clarke County
Culpeper County
Fairfax City
Fairfax County
Falls Church City
Fauquier County
Fredericksburg City
King George County
Loudon County
Manassas City
Manassas Park City
Prince William County
Spotsylvania County
Stafford County
Warren County

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED PERSONAL CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of personal care services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to the geographic location of the recipient. The fee for personal care services is an hourly fee that reimburses for authorized personal care services. This fee must cover all expenses associated with the delivery of personal care services, including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The maximum number of hours, which can be billed, is the amount on the provider's approved Plan of Care. The amount of personal care services required by each recipient shall be determined by the Pre-Admission Screening (PAS) Team and the pre-authorization contractor. This authorization for units of service will establish the maximum number of units and the allowable payment for the service. The maximum amount of respite care services hours allowed per calendar year is 720 hours.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per recipient. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED RESPITE CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of respite care services has been calculated for regions of the state and must be applied uniformly on a statewide basis according to the geographic location of the recipient. The unit of service for respite care will be defined by the number of hours of service which are provided. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The reimbursement must cover all expenses associated with the delivery of respite care services.

The amount of personal care services required by each recipient shall be determined by the PAS Team and the pre-authorization contractor. This authorization for units of service will establish the maximum number of units and the allowable payment for the service. The maximum amount of respite care services hours allowed per calendar year is 720 hours.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Providers may bill for services more than one time each month per recipient. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

To comply with federal and state mandates, a ceiling for the cost of Adult Day Health Care (ADHC) services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to geographical locality. The fee for ADHC services is a per-diem fee. A day is defined as attendance at the ADHC Center for six hours or more. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

This fee must cover all expenses associated with the delivery of services for the time the recipient is attending an ADHC Center. The per-diem reimbursement rate is considered by

DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs.

If a recipient attends the ADHC Center for less than six hours on any given day, it is considered a half day of service. At the end of the month, the half days of service may be added and rounded to the nearest whole day of service. Providers may bill for services more than one time each month per recipient. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

Any ADHC Center which is able to provide recipients with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip (to and from the recipient's residence) fee. This reimbursement for transportation must be pre-authorized by either the PAS Team or the pre-authorization contractor review staff. The per-trip reimbursement rate can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) SERVICES

The monthly rate (one unit) includes administrative costs, time, labor and supplies associated with the installation, maintenance, and monitoring of the PERS.

The one-time installation of the unit includes installation, account activation, recipient and caregiver instruction, and removal of equipment.

The rates of reimbursement for PERS monitoring and installation can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR MEDICATION MONITORING SERVICES

The rates of reimbursement for medication monitoring installation, monthly monitoring, and the bimonthly (twice per month) rate of reimbursement for PERS nursing visits to fill the medication monitoring unit can be found on the DMAS website at www.dmas.virginia.gov.

The one-time installation of the unit includes installation, account activation, recipient and caregiver instruction, and removal of equipment.

RATES OF REIMBURSEMENT FOR SERVICE FACILITATION SERVICES

The reimbursement for service facilitation services varies according to the type of services provided to the recipient. The fees must cover all expenses associated with the delivery of service facilitation services, including nursing visits. The reimbursement rates are considered by the Department of Medical Assistance Services (DMAS) as payment in full for all administrative overhead and other administrative costs that the provider incurs. Service facilitation reimbursement rates can be found on the DMAS website at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR CONSUMER-DIRECTED (CD) PERSONAL CARE AND RESPITE CARE SERVICES

The reimbursement rates for consumer-directed (CD) personal care services can be found on the DMAS web site at www.dmas.virginia.gov.

PATIENT PAY AMOUNT AND COLLECTION

PURPOSE

This form is used by a local Department of Social Services (DSS) and an Elderly or Disabled with Consumer Direction Waiver services provider to exchange information with respect to:

- The responsibility of an eligible recipient to make payment toward the cost of care;
- The admission or discharge of the recipient or death of the recipient; and
- Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay amount or to notify the local DSS of changes in the recipient's circumstances. A new form must be prepared by the local DSS at the time of each redetermination of eligibility and whenever there is any change in the recipient's circumstances that results in a change in the amount of the patient pay.

DISPOSITION OF COPIES

The provider should initiate the form upon receiving a referral from the PAS Team in order to notify the local DSS that he or she has admitted the recipient and to provide the beginning date of service. Upon determination of eligibility, the DMAS-122 form will be returned to the provider with the following information:

- Whether the recipient does or does not have financial responsibility toward the cost of care;
- The amount and sources of finances; and
- The date on which the patient pay responsibility begins.

There must be a completed DMAS-122 form in the recipient's file prior to billing DMAS. The provider with the most authorized hours is responsible for the DMAS-122 form. The provider with the most authorized hours of service per month is considered the primary service provider (PSP). Providers involved in the recipient's care must coordinate the DMAS-122 activities. For CD services, the Service Facilitator must also provide a copy of the DMAS-122 form to the Fiscal Agent. If there is a change in the patient pay amount for recipients receiving CD services,

the CD Service Facilitator must send a copy of the revised DMAS-122 to the pre-authorization contractor and the Fiscal Agent.

The patient pay amount is the recipient's contribution toward his or her care received in a calendar month. If the amount of services received by a recipient in a calendar month is equal to or less than such recipient's patient pay amount, only the amount for the services rendered should be collected from the recipient, and DMAS should not be billed for that month. If the amount of services rendered is greater than the amount of patient pay, an invoice should be submitted showing the total allowable charges and the patient pay amount. The provider will be reimbursed by DMAS for the total allowable charges less the patient pay amount. For consumer-directed services, if the amount of services rendered is greater than the amount of the patient pay, the Fiscal Agent will subtract the patient pay amount from the CD personal care aide's payroll. The recipient is responsible for paying the employee the patient pay directly.

The Fiscal Agent for this program is the Department of Medical Assistance Services (DMAS):

Department of Medical Assistance Services
Fiscal Unit – C-DPAS Program
600 East Broad Street
Richmond, Virginia 23219

Phone: 1-866-225-1768
Fax: 1-804-371-8892 (for general information and DMAS-122 forms only)

The patient pay amount is that amount of a Medicaid recipient's income that must be contributed to the cost of his or her care. The amount of patient pay is determined by the DSS based on the recipient's income and medically related deductions. It is the responsibility of the DSS to notify the recipient and the provider of any change in the patient pay amount. Patient pay **estimates** are obtained by the PAS Team to inform the recipient of the estimated patient pay amount and should be included on the DMAS-97 form. The provider should immediately initiate a DMAS-122 form and send it to the local DSS upon beginning services so that the DSS can notify the provider of the actual patient pay amounts. The provider should compare these actual figures against the PAS Team's estimates. If the two do not correspond, the provider should notify the recipient and the Fiscal Agent (if applicable) of the patient pay amount on the DMAS-122 form and bill DMAS accordingly.

Upon receipt of a referral in which a patient pay amount for services is indicated, the primary care provider (PCP) should verify that the recipient understands and agrees to his or her patient pay obligations. Medicaid suggests that this verification be in the form of a signed statement of obligation and that the patient pay amount be collected at the beginning of the month. It is the responsibility of the provider to collect the patient pay amount. For consumer-directed services, it is not the responsibility of the Service Facilitator to collect the recipient's patient pay amount. It is the recipient's responsibility to ensure the patient pay amount is given to the personal care aide to cover the amount of personal care services authorized. DMAS will not reimburse a provider for any portion of the patient pay amount.
In those instances where the patient pay responsibility usually exceeds the amount of services authorized for one provider, the provider will divide the amount of patient pay so that the statement obligation signed by the participant indicates the amount the participant will pay

monthly to one provider and the amount the participant will pay monthly to a second service provider. The primary service provider must provide a copy of this statement to the secondary service.

For additional information and examples of patient pay collection when a recipient is receiving more than one waiver service, see Chapter IV's Patient Pay Amount section on page 6.

In the event that the recipient does not pay the patient pay amount in a timely manner, the provider must make a reasonable effort to notify the recipient/family of the situation in an effort to collect the required amount. A reasonable effort shall be defined as three written notifications to the recipient.

The recipient's failure to pay the patient pay amount may affect his or her Medicaid eligibility. Therefore, if the provider is unable to collect the patient pay amount, the provider must also notify the local DSS eligibility worker having case responsibility for the recipient. For consumer-directed services, if the Service Facilitator becomes aware that the recipient is not paying the patient pay amount to the personal care aide, the Service Facilitator must also notify the local DSS eligibility worker having case responsibility for the recipient. This notification must be in writing and a copy retained in the recipient's record by the provider. It is the responsibility of the recipient to pay the patient pay to the provider or, if applicable, to the consumer-directed personal care aide. The provider or the personal care aide, if applicable, has the right to decide whether to continue service delivery to a recipient who neglects to pay his or her patient pay amount. DMAS will not reimburse the provider or the personal care aide, if applicable, for the patient pay amount that is not paid by the recipient.

If, after a reasonable effort to collect the patient pay amount, the provider decides to discontinue services, the provider must give the recipient/family five days' written notice of discontinuance of services. Such notice must include the reason for discontinuance and the effective date. A copy of this notification must be sent to the local DSS eligibility worker. A copy of all correspondence must be retained in the recipient's record with the provider and a copy sent to the pre-authorization contractor.

MEDICAID BILLING INVOICES FOR ELDERLY OR DISABLED WITH CONSUMER DIRECTION (EDCD) WAIVER SERVICES

The billing invoice for EDCD Waiver services is the CMS-1500 (12-90) Claim Form.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information, contact our Fiscal Agent, First Health Services Corporation:

Phone: 1-800-924-6741
Fax: 1-804-273-6797

First Health's website: http://virginia.fhsc.com
Email: edivmap@fhsc.com

Mailing Address:

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING OF CLAIMS

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which are not submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments (see "Exhibits" section at the end of this chapter). Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility -** Medicaid eligibility can begin as early as the first day of the third month prior to the month the application was submitted for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility -** Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered services for a period of delayed eligibility will be notified by a copy of a

letter from the local DSS, which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the dated letter from the local DSS indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) Claim Form, enter "ATTACHMENT" in Locator 10D and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Denied Claims** - Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 (12-90) Claim Form as explained under the "Instructions for the Use of the CMS-1500 (12-90) Billing Form" elsewhere in this chapter.

  - Attach written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month time period. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See "Exhibits" section at the end of this chapter.)

  - Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) Claim Form.

  - Submit the claim in the usual manner by mailing the claim to:

    Department of Medical Assistance Services
    Practitioner
    P. O. Box 27444
    Richmond, Virginia 23261-7444

    The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of these specified criteria:

    1) **Accident Cases** – The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

2) **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

BILLING INVOICES

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the three billing invoices to be used:

- Health Insurance Claim Form, CMS-1500 (12-90)
- Title XVIII (Medicare) Deductible and Co-insurance Invoice (DMAS-30), Revised 06/03
- Title XVIII (Medicare) Deductible and Co-insurance Adjustment Invoice (DMAS-31)

NOTE: Virginia Medicaid will accept an original Health Insurance Claim Form, CMS-1500 (12-90), printed in red ink with the appropriate certifications on the reverse side (bar coding is optional). Additionally, only the 12-90 version of the CMS-1500 Claim Form will be accepted. Previous editions or other versions of this form will not be accepted.

The requirement to submit claims on an original CMS-1500 (12-90) Claim Form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form. Therefore, these statements become part of the original billing invoice.

REPLENISHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing for DMAS-covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) Claim Form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS website (www.dmas.virginia.gov). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page, and select "Provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS Form Order Desk at 1-804-780-0076.

For any requests for information or questions concerning the ordering of forms, call 1-804-780-0076.

REMITTANCE VOUCHER (PAYMENT VOUCHER)

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a listing of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five years.

The remittance voucher includes an address location that contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change of address, the U.S. Postal Service will not forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change of address to allow the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest, and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set will be used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835, the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice, please contact our Fiscal Agent, First Health, at 1-800-924-6741.

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond area and out-of-state
1-800-552-8627	In-state, toll-free long distance

Enrollee verification may be obtained by telephoning:

1-800-884-9730	Toll-free throughout the United States
1-804-965-9732	Richmond and surrounding counties
1-804-965-9733	Richmond and surrounding counties

BILLING PROCEDURES

The appropriate claim form or billing invoice must be used by physicians and other practitioners when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will be ended for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or

before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides, version 4010A1:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization (PA) request and response
- Unsolicited 277 for reporting information on pended claims

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our Fiscal Agent's website: http://virginia.fhsc.com.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) CLAIM FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90) Claim Form, must be used. The following instructions have numbered items corresponding to fields on the CMS-1500 Claim Form. The required and conditional fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information, and provider-specific instructions are found at the end of this chapter.

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM, CMS-1500 (12-90), AS A BILLING INVOICE

The purpose of the CMS-1500 Claim Form is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of CMS-1500 Claim Form is in the "Exhibits" section at the end of this chapter.)

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the recipient receiving the service as it appears on the identification card.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex

9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.)** **a. Employment b. Auto Accident c. Other Accident (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED**	**Date of Current Illness, Injury, or Pregnancy** **(Date care began,** located on the DMAS-93 form)
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the Virginia Medicaid provider number of the referring physician. See the following pages for special instructions for specific services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use

20	NOT REQUIRED	Outside Lab
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.**
22	**CONDITIONAL**	**Medicaid Resubmission - Required for Adjustment and Void Invoices. See the instructions for Adjustment and Void Invoices.**
23	**REQUIRED**	**Prior Authorization (PA) Number – Enter the PA number for the approved service.**
24A	**REQUIRED**	**Dates of Service - Enter the from and thru dates in a two-digit format for the month, day, and year (e.g., 04/01/02). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service - Enter the two-digit CMS code which describes where the services were rendered.**
24C	**REQUIRED**	**Type of Service - Enter the one-digit CMS code for the type of service rendered.**
24D	**REQUIRED**	**Procedures, Services, or Supplies – See pages following the instructions for special billing instructions.** **CPT/HCPCS - Enter the 5-character CPT/HCPCS Code which describes the procedure rendered or the service provided. See the attached code list for special instructions if appropriate for the service provided.** **Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of the attached documentation.**
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.**
24F	**REQUIRED**	**Charges - Enter the total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for the service provided.**

24G	**REQUIRED**	**Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable for the service provided.**
24H	**CONDITIONAL**	**EPSDT or Family Plan - Enter the appropriate indicator. Required only for EPSDT or family planning services.** **1 - Early and Periodic, Screening, Diagnosis, and Treatment Program Services** **2 - Family Planning Service**
24I	**CONDITIONAL**	**EMG (Emergency) – Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**REQUIRED**	**COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for service provided.** **2 - No Other Carrier** **3 - Billed and Paid** **5 - Billed, No Coverage**
24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier or the patient pay amount if Block 24J is coded "3." See special instructions if required for service provided.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	**OPTIONAL**	**Patient's Account Number – Up to 17 alpha-numeric characters are acceptable.**
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	**CONDITIONAL**	**Amount Paid – Enter patient pay amount for personal care only**
30	NOT REQUIRED	Balance Due

31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address, ZIP Code, & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number (servicing provider) in the PIN field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code. Enter Group # (billing provider number) if applicable.**

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), as a Billing Invoice except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the four-digit code identifying the reason for the submission of the adjustment invoice:

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting, admitting, referring, prescribing provider identification number

1053 Adjustment reason in the Miscellaneous Category

Original Reference Number – Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 Claim Form submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions for the Completion of Health Insurance Claim Form, CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), as a Billing Invoice, except for the locator indicated below.

Locator 22

MEDICAID RESUBMISSION

Code - Enter the four-digit code identifying the reason for the submission of the Void Invoice:

1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong enrollee eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Recipient not my patient
1052 Void is for miscellaneous reasons
1060 Other insurance is available

Original Reference Number – Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 Claim Form submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

SPECIAL BILLING INSTRUCTIONS FOR CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each Provider Manual.

When treating a restricted enrollee, a physician covering for the PCP or on referral from the PCP must place the PCP's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the PCP, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.
17a	When a restricted enrollee is treated on referral from the primary physician, enter the primary physician's Medicaid provider number (as indicated on the DMAS-70 Referral Form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

SPECIAL BILLING INSTRUCTIONS - MEDALLION

PCPs bill for services on the Health Insurance Claim Form, CMS-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid *Physician* Provider Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the CMS-1500 Claim Form. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

SUBMISSION OF BILLING INVOICES

Providers must submit claims using the actual dates of service rendered. Invoices must include only allowable charges for the number of hours for services rendered. Any charges submitted prior to the date authorized by the PAS Team as the begin date will be rejected. Invoices must be submitted in the purple-edged, self-addressed envelope provided by DMAS. The provider copy of the invoice must be retained by the provider for record-keeping. All invoices must be mailed with proper postage. Messenger or hand deliveries will not be accepted. Invoices and adjustments should never be mailed to the DMAS address. This will only delay processing. Providers should allow at least 30 days for claims processing. The mailing address is:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL/RESPITE CARE

Locator 14 Date of Current Illness, Injury, or Pregnancy
Date care began is located on the DMAS-93 form (P.A. Letter)

Locator 24D Procedures, Services, or Supplies

CPT/HCPCS - Enter the appropriate procedure code from the following list:

T1019 Personal Care

T1005 Respite care services, aide/hr.

S9125 Respite care services, LPN/hr.

Locator 24J COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay.)

Locator 24K Reserved for Local Use

Enter the patient pay amount except for Personal Care. (For Personal Care, see instructions for Locator 29). Patient pay and primary carrier payments can be combined if applicable. EOB should be attached to claim.

Locator 29 Amount Paid

Enter the patient pay amount for Personal Care only.

SPECIAL BILLING INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC)

The providers of ADHC must complete the CMS-1500 (12-90) Claim Form. The claim form must be completed as normal with a few special billing instructions:

Locator 24D — CPT/HCPCS - Enter the appropriate procedure code from the following list for the service rendered:

S5102 Adult Day Health Care Services

A0120 Adult Day Health Care Transportation

Locator 24J — COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay.)

Locator 24K — Reserved for Local Use
Enter the payment from other insurance, if applicable.

Locator 29 — All claims submitted to DMAS on or after April 15, 2005, with a patient pay amount, must have the patient pay amount recorded in block 29 of the claim form.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Locator 24D Procedures, Services, or Supplies

CPT/HCPCS – Enter the appropriate procedure code from the following list:

S5160 PERS Installation
S5161 PERS Monitoring

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

Providers of PERS services for the EDCD Waiver must submit their CMS-1500 Claim Form and approval letter from the pre-authorization contractor to the following address until further notice:

DMAS
Customer Services Unit Supervisor
Division of Program Operations
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

SPECIAL BILLING INSTRUCTIONS FOR MEDICATION MONITORING

Locator 24D Procedures, Services, or Supplies

CPT/HCPCS – Enter the appropriate procedure code from the following list:

S5160 with modifier U1
Medication Monitoring unit installation
S5185 Medication Monitoring unit monthly monitoring
H2021 with modifier TD
Medication Monitoring RN visit
H2021 with modifier TE
Medication Monitoring LPN visit

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

SPECIAL BILLING INSTRUCTIONS FOR SERVICE FACILITATION SERVICES FOR CONSUMER-DIRECTED (CD) SERVICES

Locator 24D Procedures, Services, or Supplies

It is essential that the provider submit all claims in a timely manner, preferably within 30 days of the date that the service was provided.

CPT/HCPS - Enter the appropriate procedure code from the following list.

NEW NATIONAL CODE	MODIFIER	DESCRIPTION
H2000		Comprehensive Visit
S5109		Consumer Training
99509		Routine Visit
T1028		Reassessment Visit
S5116		Management Training
99199	U1	Criminal Record Check
99199		CPS Registry Check
S5126		Personal Care
S5150		Respite Personal Care

SPECIAL BILLING INSTRUCTIONS FOR RECEIVING SERVICES FROM MULTIPLE PROVIDERS ON THE SAME DAY

For individuals who receive the same service from two different providers on the same day, the first provider's claim is to be billed with modifier 77 on the claim. The second provider must submit their claim with the national code and modifier 77. Otherwise, the second provider's claim will be denied due to duplication of services from the first provider. The modifier is placed in block 24D on the CMS-1500 Claim Form.

COMPUTER-GENERATED INVOICES

Providers may submit claims by direct dial-up at no cost per claim, using toll-free telephone lines. Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Most personal, mini, or mainframe computers can be used for electronic billing.

Providers wishing approval to submit electronic media claims should write to the Coordinator of Electronic Media Claims, who will advise the proper steps for accomplishing this type of billing. The address to be used is:

Coordinator
Electronic Media Claims
FIRST HEALTH Services Corporation
4300 Cox Road
Glen Allen, Virginia 23060

PRE-AUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY

For services requiring pre-authorization, all pre-authorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, the pre-authorization contractor will perform the after-the-fact authorizations.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

Remittance Voucher

- **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.

No Response

If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

EXHIBITS

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	**MM**	**DD**	**CCYY**	**Sequence Number (5 digits)**
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First Name:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)** _____

COMMENTS: _____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.) IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.virginia.gov.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number	02 Last Name	03 First Name

04 Recipient ID Number	05 Patient's Account Number	06 Recipient's HIB Number (Medicare)

1

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

2

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

3

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

4

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

24 Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the 9-digit Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT ☐ 092	VOID ☐ 094	2 PROVIDER I.D. NO. (7)	A REFERENCE NUMBER (9)	B REASON	C INPUT CODE
3 RECIPIENT'S LAST NAME	FIRST NAME	4 RECIPIENT'S I.D. NUMBER (12)	5 PATIENT ACCOUNT NUMBER	6 RECIPIENT'S HIB NUMBER (MEDICARE)	

0.

7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)	8 TYPE COVERAGE (MEDICARE)	9 DIAGNOSIS	9A PLACE OF TREAT.	10 ACCIDENT/EMERG. INDICATOR	11 TYPE SERV.	11A PROCEDURE CODE (5)	11B VISITS/UNITS STUDIES (3)	12 DATE OF ADMISSION	13 STATEMENT COVERS PERIOD
☐ 2 NO OTHER COVERAGE ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COVERAGE	☐ A ☐ B			☐ ACC ☐ EMER ☐ OTHER				MO. (2) DAY (2) YEAR (2)	FROM MO. (2) DAY (2) YEAR (2) THRU MO. (2) DAY (2) YEAR (2)

14 CHARGES TO MEDICARE	15 ALLOWED BY MEDICARE	16 PAID BY MEDICARE	17 DEDUCTIBLE	18 COINSURANCE	19 PAID BY CARRIER OTHER THAN MEDICARE	20 PATIENT PAY AMOUNT LTC ONLY

_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE _____ DATE

ORIGINAL COPY

DMAS 31 R 6/96